Statement of

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Leveraging Mutual Aid for Effective Emergency Response

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"Leveraging Mutual Aid for Effective Emergency Response"

I. Introduction

Chairman Cuellar, Ranking Member Dent and members of the Subcommittee on Emergency Communications, Preparedness, and Response, I greatly appreciate the opportunity to speak before you today. My name is Jim McPartlon and I currently serve as the President of the American Ambulance Association (AAA). I started in the emergency medical services (EMS) sector as an EMT 30 years ago and today I am the Vice President of Mohawk Ambulance Service which provides emergency and non-emergency ambulance services to the cities of Albany, Schenectady and Troy, New York and the surrounding areas.

The AAA is the primary trade association representing ambulance service providers that participate in serving communities with emergency and non-emergency ambulance services. The AAA is composed of more than 700 ambulance operations and has members in every state; transporting over 6 million patients every year. AAA members include private, public and fire and hospital-based providers covering urban and rural areas. The AAA was formed in response to the need for improvements in pre-hospital healthcare and medical transportation.

It is in my elected role as President of the AAA that I appear before you today, to provide the perspective of the Association regarding "Leveraging Mutual Aid for Effective Emergency Response."

II. Recommendations for More Effective Use of Ambulance Services

While great strides have been made over the years to better leverage mutual aid for emergency response, improvements are still required to more effectively use ambulance services. Ambulance services are a mix of governmental and nongovernmental providers which serve alongside our fire and law enforcement colleagues and are a critical part of the emergency response system. Our operations are comprised of paramedics, emergency medical technicians and other emergency medical service professionals. However, ambulance service providers, in particular nongovernmental, often face difficulty in being properly included in the preparing and response to catastrophic events.

To ensure that all ambulance service providers can be effectively utilized under mutual aid for emergency response, I recommend to the Committee the following:

1. Ensure that adequate federal homeland security funding is available to governmental and nongovernmental ambulance service providers for personal protective equipment, training and other resources necessary to support critical public safety missions.
2. Further integrate governmental and nongovernmental ambulance service providers into local, state and federal planning and exercises and require that nongovernmental ambulance service providers be included under appropriate mutual aid agreements such as Emergency Management Agreement Compacts (EMACs);

3. Strengthen intrastate mutual aid as an essential component of the National Response Framework capability; and,
4. Increase access for governmental and nongovernmental ambulance service providers to funding for emergency communications equipment and systems in order to ensure that our systems achieve interoperability with other first responders.

III. Role of Ambulance Service Providers as First Responders

The immediate response to a catastrophic disaster, act of terrorism or other public health emergency involves many local public safety, public health and health care organizations. As first responders, America's ambulance service providers are an essential resource and perform vital services as part of each community's emergency response system. This was abundantly clear during the response to Hurricanes Katrina and Rita in which over five hundred ambulances comprised of paramedics and emergency medical technicians from around the country, assisted patients in need and local agencies in their response to the catastrophic events along the gulf coast.

During the response to a natural or man-made disaster, the role of an ambulance service provider includes patient care and triage, decontamination, treatment, and transport. Their role also includes hazard recognition, symptom surveillance and reporting, disaster shelter staffing and re-supply, on-scene medical stand-by, and transport and redistribution of patients to better utilize available receiving hospital resources. Many agencies have begun developing "strike teams" or "disaster response teams" to effect rapid deployment in support of local, state and federal resources.

America's 9-1-1 ambulance service providers are a diverse group of public, private, hospital and volunteer-based services. Indeed, many stories of heroism and sacrifice include representatives from all these agencies as they have responded to natural and man-made disasters.

During a catastrophic disaster, local ambulance services providing emergency medical services are an essential resource and a vital part of the emergency response system. In a review of the nation's largest 200 cities, including those most vulnerable to attack, emergency ambulance services are provided by private, public, volunteer, and hospital-based agencies. Experience has shown that non-emergency as well as emergency ambulance service providers often serve as "first responders" by dedicating essential vehicle and personnel resources within the first hours of a disaster.

IV. Importance of Private-Public Partnerships

Unlike fire and police, the private sector is a major provider of emergency and non-emergency ambulance services across the nation. While the emergency medical service system design varies greatly, in almost all cases there is participation by both public and private entities. For this reason, it is critical that a strong partnership exist between government and nongovernmental first responders and those who manage the total

emergency response system. Furthermore, the successful management of any emergency response is directly related to the coordination of all assets being deployed.

The recent TOPOFF 4 exercise in Phoenix illustrates the need for improved integration and overall system response coordination of nongovernmental providers. While nongovernmental ambulance service providers played an extremely important role in the exercise, providers were placed in the private sector operations center and separated from their fellow governmental first responders and emergency health care workers. This removed ambulance officials from direct interaction with managers of the emergency response system and delayed situational awareness and response by the ambulance officials. It is ironic that the private sector operations center was located in the direct path of the radioactive debris plume from the dirty bomb. Those responsible for mobilizing the front line of the emergency medical response would be therefore incapacitated from directing critical care to victims as well as other first responders.

V. Current Challenges with Mutual Aid

The National Response Framework recognizes that all disasters are local; therefore the response must begin with the utilization of the closest available units i.e. the local response. As the disaster (or preparation for the disaster) becomes larger in scale, the greater the need is for an expanded response, beginning with neighboring communities, neighboring states and finally a federal response. Because a majority of disasters are smaller in scale, attention needs to be paid on building local, state and interstate mutual aid systems allowing the closest resources to mobilize and respond.

Although EMAC is an efficient way to mobilize interstate mutual aid, challenges still exist to the development and deployment of the system. Each state develops a unique mutual aid agreement and there are few standards and procedures that exist across the nation. For example, only 17 states have arranged to utilize private sector resources to fulfill EMAC requests. Almost two-thirds of states do not allow the inclusion and deployment under EMAC of nongovernmental ambulance service providers which constitute the majority of available ambulances and personnel. Not including nongovernmental providers under EMAC means that resources from further away will need to be deployed wasting precious time. When nongovernmental ambulance resources are used, many providers report significant delays in getting reimbursed for their costs and many states reimburse below cost. Finally, coordination between the Federal response and the state response is often lacking, with services being deployed to the same location and state EMS coordinating officers unaware of unit availability and location.

The bridge collapse in Minneapolis, Minnesota on August 1, 2007 demonstrated how a strong interstate mutual aid system can work. During rush hour the main spans of the I-35 Bridge collapsed, killing thirteen and injuring one hundred. Immediately after the collapse, mutual aid from the seven closest counties responded and within two hours all patients were transported to local hospitals and trauma centers for treatment. Without a well-coordinated and robust mutual aid system; patient treatment and transport would

have been delayed and additional loss of lives possible. Every citizen, in every city and county in the U.S. deserves the quickest and best possible pre-hospital healthcare and a strong Mutual Aid system is one of the ways to insure it.

VI. Further Detail on Recommendations

1. Ensure adequate federal homeland security funding is available to governmental and nongovernmental ambulance service providers for personal protective equipment, training and other resources necessary to support their critical public safety missions.

Many ambulance service personnel that responded to major incidents mentioned in this testimony continue to lack the appropriate personal protective equipment necessary for the environments in which they would be operating in including hazardous scenes and toxic floodwaters. This is a direct result of the lack of federal and state homeland security funding for ambulance service providers. In 2005 and 2006, the Department of Homeland Security reported that emergency medical service providers received only 4% of the homeland security funding distributed to first responders.

To provide an effective response and to protect the health and safety of our personnel, all medics, including those who have the potential to respond in a mutual aid capacity, must be protected. Personnel must have access to and must be trained on the appropriate procedures for use of personal protective equipment that may include tyvec suits, gloves, masks, rescue helmets, bunker gear and bio-hazard storage and disposal equipment. Procedures must be developed to assure access to vaccines and antidotes when necessary. In order for on scene personnel to be effective in the incident command structure, these on scene resources are essential. Ambulance logistics such as refueling, repair and restocking are important considerations as well.

2. Further integrate governmental and nongovernmental ambulance service providers into local, state and federal planning and exercises and require that nongovernmental ambulance service providers be included under appropriate mutual aid agreements such as Emergency Management Agreement Contracts (EMACs).

Ambulance service providers operate at the intersection of the public health, public safety and health care fields, and there is great diversity in the types of providers delivering ambulance services and the designs of those delivery systems. This diversity contributes to the fact that many ambulance services are sometimes excluded from local and state emergency preparedness and response activities. Furthermore, there are compliance issues associated with the general requirements of FEMA to obtain mutual aid agreements prior to an event in order to be eligible for Stafford Act Public Assistance federal disaster reimbursement. Ambulance service providers are not even listed as emergency work under the Stafford Act and thus providers face barriers in being eligible for reimbursement. Ambulance providers respond to mutual aid requests from long distances—including neighboring cities, counties and even states. It is difficult for a local ambulance provider to secure prior mutual aid agreements with every local community that may request services in the future.

3. Strengthen intrastate mutual aid as an essential component of the National Response Framework capability.

Intrastate mutual aid plans need to be strengthened so local communities can reach out to their state when in need of help and so states will have resources organized for sending to neighboring states when requested through EMAC. As recent catastrophes have demonstrated, governmental and nongovernmental ambulance service providers are an essential asset in the evacuation, response and recovery phases of a national disaster. Governmental and nongovernmental ambulance service providers must be fully integrated in the planning, training and exercise activities at the local, state and federal level. State and local EMS officials need to work hand in hand with state and local emergency management officials as well as with their colleagues in the fire service and law enforcement. Practical and integrated systems must be instituted to inventory disaster response assets state by state to streamline and document all mutual aid requests for assistance. As local, regional and state mutual aid plans are strengthened and broadened, the planning process should formalize mutual aid agreements with all potential responders and service providers.

4. Increase access for governmental and nongovernmental ambulance service providers to funding for emergency communications equipment and systems in order to ensure that our systems achieve interoperability with other first responders.

Based on a recent AAA membership survey, AAA members have reported that communications systems and equipment remain a significant operational need. In many communities, ambulance service providers also face challenges obtaining access to radio frequencies. During recent incidents of major consequence, AAA members experienced serious gaps in maintaining communications with incident command authorities.

To ensure that all ambulance service providers can communicate without problem during an incident, two objectives must be met. First, governmental and nongovernmental ambulance service providers must be eligible for grants to assure communications systems support our critical public safety mission. Second, additional spectrum and systems must be made available to government and non-government emergency medical service providers and providers must be involved in the communications interoperability planning activities at the local, state, regional and national level. Studies clearly show the lack of a compatible spectrum as well as a spectrum that is actually available to local emergency responders, including ambulance service providers. Only then will ambulance services providers be able to work efficiently with incident command and other first responders.

VII. Conclusion

In conclusion, ambulance service providers stand ready with our fire and law enforcement colleagues to assist in responding to future catastrophic events. As demonstrated in the response to Hurricanes Katrina and Rita and more recently with the

bridge collapse in Minnesota, governmental and non-governmental ambulance service providers are a critical component of the state, local and the national response to catastrophic events. In these types of situations, all ambulance service providers, regardless of provider type or whether the units are emergency or non-emergency, become potential first responders.

To assure the effective involvement of ambulance service providers in mutual aid for emergency response, the following guiding principles should apply:

- Establish funding mechanisms to support and maintain the essential capabilities of all ambulance service providers;
- Require that all states include private ambulance service providers in their Emergency Management Agreement Contracts; and,
- Ensure access for ambulance service providers to interoperability communications equipment and systems.

I again thank Chairman Cuellar, Ranking Member Dent and members of the Subcommittee on Emergency Communications, Preparedness, and Response for the opportunity to testify on this important issue.

I will be more than happy at the appropriate time to answer questions that Subcommittee members have for me.

Thank you.